

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Cecil</u>		5742		79		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Cherry Hill</u> (No. <u>Innane</u> )		St.; Ward				Registration Dist. No. <u>92</u>	
2 FULL NAME <u>Maria Beer</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]					
PERSONAL AND STATISTICAL PARTICULARS							
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Col</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)					
6 DATE OF BIRTH <u>unknown</u> (Month) (Day) (Year)		7 AGE <u>57</u> yrs. <u>1</u> day, <u>1</u> hr. <u>1</u> min. ? OR LESS than 1 day, <u>1</u> hr. <u>1</u> min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		<u>House work</u>					
9 BIRTHPLACE (State or country)		<u>Cecil Co</u>					
PARENTS	10 NAME OF FATHER	<u>unknown</u>					
	11 BIRTHPLACE OF FATHER (State or country)	<u>unknown</u>					
	12 MAIDEN NAME OF MOTHER	<u>unknown</u>					
	13 BIRTHPLACE OF MOTHER (State or country)	<u>unknown</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs May Cameron</u> (Address) <u>P.O. Childs R.F.D. #1</u>							
15 Filed <u>June 1</u> , 191 <u>4</u> <u>J. Frank Frazer</u> REGISTRAR		16 DATE OF DEATH <u>June 1</u> , 191 <u>4</u> (Month) (Day) (Year)					
		17 I HEREBY CERTIFY, That I attended deceased from <u>June 1</u> , 191 <u>4</u> , to <u>June 1</u> , 191 <u>4</u> , that I last saw h. <u>ee</u> alive on <u>June 1</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>5:30 P.</u> m. The CAUSE OF DEATH* was as follows: <u>Acute Dilative Heart</u> (Duration) <u>1</u> yrs. <u>1</u> mos. <u>1</u> ds. Contributory <u>Mitral Valvular Disease</u> Secondary <u>1</u> yrs. <u>1</u> mos. <u>1</u> ds. (Signed) <u>Wm. Cawley</u> , M. D. , 191 <u>4</u> (Address) <u>Black</u>					
		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>1</u> yrs. <u>1</u> mos. <u>1</u> ds. In the State <u>1</u> yrs. <u>1</u> mos. <u>1</u> ds. Where was disease contracted, If not at place of death? Former or usual residence					
		19 PLACE OF BURIAL OR REMOVAL <u>Potters Field Cherry Hill</u>				DATE OF BURIAL <u>June 2</u> , 191 <u>4</u>	
		20 UNDERTAKER <u>Amos R. Pope</u>				ADDRESS <u>Electra Ind</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECORDED

JUL 6 1914

BUREAU, V. S.

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## 1 PLACE OF DEATH

5743

County BeallSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96Village or City Conowingo Md (No. 30)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Raymond Berry

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH Feb 17, 1914  
(Month) (Day) (Year)

7 AGE 4 yrs. 4 mos. — ds. If LESS than 1 day, hrs. — min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work none - (Infant)  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Beall Co Md

10 NAME OF FATHER William Sanders

11 BIRTHPLACE OF FATHER (State or country) New Ark Del

12 MAIDEN NAME OF MOTHER Neots V Berry

13 BIRTHPLACE OF MOTHER (State or country) Beall Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rowland Berry(Address) Conowingo Md

15 Filed June 19, 1914 V. S. R. Kauffman  
Cor. Department REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 17, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1914, to June 17, 1914,

that I last saw him alive on June 10, 1914,

and that death occurred on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH\* was as follows:

Tubercular Meningitis

primary  
(Duration) yrs. 4 mos. — ds.

Contributory (Secondary) Tubercular gland

(Signed) Wm. R. Dean Coroner, June 19, 1914. (Address) Edgemoor Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mt. Zion cemetery DATE OF BURIAL June 19, 1914

20 UNDERTAKER State B. Loh ADDRESS Coloma Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

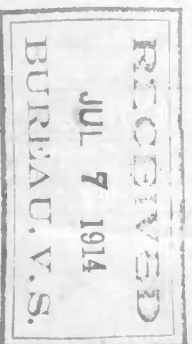
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH <b>5744</b>		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <b>Essex</b>		Registered No. <b>94</b>	
Village or City <b>North East</b> (No. <b>64</b> )		St: _____ Ward) _____	
2 FULL NAME <b>Elizabeth C Biddle</b>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <b>Female</b>	4 COLOR OR RACE <b>White</b>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <b>Widow</b> (Write the word)	
6 DATE OF BIRTH <b>July 23rd, 1884</b> (Month) (Day) (Year)			
7 AGE <b>79</b> yrs. <b>11</b> mos. <b>ds.</b>		If LESS than 1 day, _____ hrs. OR _____ min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <b>Talorress</b> (b) General nature of industry, business, or establishment in which employed (or employer) _____			
9 BIRTHPLACE (State or country) <b>Montgomery Pa</b>			
PARENTS	10 NAME OF FATHER <b>David McVaugh</b>		
	11 BIRTHPLACE OF FATHER (State or country) <b>not known</b>		
	12 MAIDEN NAME OF MOTHER <b>Phoebe Cook</b>		
	13 BIRTHPLACE OF MOTHER (State or country) <b>New Jersey</b>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <b>Sarah C Simpser</b> (Address) <b>North East Md</b>			
15 Filed <b>June 27, 1914</b> <b>E. Biddle</b> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <b>June 27, 1914</b> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <b>June 8, 1914</b> to <b>June 27, 1914</b> , that I last saw him alive on <b>June 26, 1914</b> and that death occurred on the date stated above, at <b>12</b> m. The CAUSE OF DEATH* was as follows: <b>Cerebral Apoplexy</b> (Duration) _____ yrs. _____ mos. <b>18</b> ds. Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <b>W. L. Campbell</b> M. D. <b>June 27, 1914</b> (Address) <b>North East Md.</b> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <b>North East Md</b>		DATE OF BURIAL <b>June 29, 1914</b>	
20 UNDERTAKER <b>W. M. Pierson</b>		ADDRESS <b>North East Md</b>	



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*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name of organ: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubercular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or concurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anaemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc. When a definite disease can be ascertained as the cause, always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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**1 PLACE OF DEATH** 5745  
 County Cecil  
 Village or City Elkton (No. Union Hospital St. al Ward) Registration Dist. No. 94  
**2 FULL NAME** Ida Curtis

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

**3 SEX** Female **4 COLOR OR RACE** col **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** Single  
 (Write the word)

**6 DATE OF BIRTH** May 14, 1901  
 (Month) (Day) (Year)

**7 AGE** 13 yrs. 17 mos. 17 ds. **IF LESS than** 1 day, \_\_\_\_ hrs. OR \_\_\_\_ min. ?

**8 OCCUPATION**  
 (a) Trade, profession, or particular kind of work School  
 (b) General nature of industry, business, or establishment in which employed (or employer)

**9 BIRTHPLACE** (State or country) Cecil Co md

**10 NAME OF FATHER** Alexander Robertson

**11 BIRTHPLACE OF FATHER** (State or country) cecil county

**12 MAIDEN NAME OF MOTHER** Josephine curtis

**13 BIRTHPLACE OF MOTHER** (State or country) verginia

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Josephine curtis

(Address) North East Rd No 3

**15** Filed June 2, 1914 Joseph Biddle  
decal REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 94

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

**16 DATE OF DEATH** June 1, 1914  
 (Month) (Day) (Year)

**17 I HEREBY CERTIFY, That I attended deceased from** Mar 20, 1914 to June 1, 1914

that I last saw him alive on May 31, 1914

and that death occurred on the date stated above, at 9 A m.

The CAUSE OF DEATH\* was as follows:

Subcutaneous Emphysema  
 (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

**Contributory**  
 Secondary And Cawley (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) And Cawley, M. D.  
 191\_\_\_\_ (Address) Elkton md

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**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residences

**19 PLACE OF BURIAL OR REMOVAL** Sent Marks Elkton **DATE OF BURIAL** June 3, 1914

**20 UNDERTAKER** H. M. Pierson **ADDRESS** North East  
md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

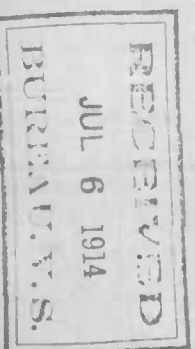
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**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

5746

County

Becil

Village or City

Near Blake (No.

St.

Ward)

2 FULL NAME

Elisha R. Ewing

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

93

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widower

6 DATE OF BIRTH

Apr. 1, 1822  
(Month) (Day) (Year)

7 AGE

92 yrs. 2 mos. 24 ds. OR LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ mo. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Farmer retired  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Becil Co. Md.

## PARENTS

10 NAME OF FATHER

John W. Ewing

11 BIRTHPLACE OF FATHER (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Miss Rogers

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Arthur J. Ewing

(Address)

Lincoln, Uni. Pa.

15

Filed

June 29, 1914 E. F. Straight

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 26, 1914  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 13, 1914, to June 26, 1914  
that I last saw him alive on June 22, 1914

and that death occurred on the date stated above, at 11 P. m.

The CAUSE OF DEATH\* was as follows:

Fatty Degeneration of  
the Heart

About (Duration) 2 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory (Secondary)

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Chas. F. Miller, M. D.

June 27, 1914 (Address) North East, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. to the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. John's Md. June 26, 1914

20 UNDERTAKER

ADDRESS

B. Co. Mason Nottingham

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

R. L. Pa.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

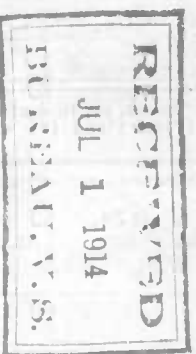
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 10 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 5747

County CecilVillage or City Aikim (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)2 FULL NAME Grace M. FisherSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) —

6 DATE OF BIRTH June 12, 1914  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 17 ds. IF LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work. \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Aikim Md

10 NAME OF FATHER Grover C. Fisher

11 BIRTHPLACE OF FATHER (State or country) Cecil Co

12 MAIDEN NAME OF MOTHER Marie Cunningham

13 BIRTHPLACE OF MOTHER (State or country) Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Grover C. Fisher(Address) Aikim. Md

15 Filed June 30, 1914 M. R. Gannon  
M. R. Gannon REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 29, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw him alive on June 28, 1914

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Infected Heart Closure  
then in premature birth

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Dr. M. Stump, M. D.

June 28, 1914 (Address) Pomquet MD

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Marks Cemetery June 30, 1914

20 UNDERTAKER ADDRESS

W. C. Jackson Plymouthdale

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

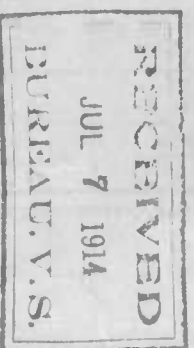
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The statement worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

5748

County

Bowie

Village or City

New Baltimore

(No.)

St;

Ward)

Registered No.

91

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

William Harmon Foster

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word)

Single

6 DATE OF BIRTH

Don't know

(Month)

(Day)

(Year)

7 AGE

About 57

yrs.

mos.

ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Lafayette

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Frederick Foster

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Sarah Buster

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leas Foster

(Address)

Chesapeake City Md

15

Filed

June 11, 1914

J. S. Sauter

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

6

8

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

June 5<sup>th</sup> 1914 to June 8 1914

that I last saw him alive on June 7 1914.

and that death occurred on the date stated above, at 12 P. m.

The CAUSE OF DEATH\* was as follows:

Cerebral Haemorrhage

(Duration)

yrs.

mos.

ds.

Contributory (Secondary)

Bright's disease

(Duration)

yrs.

mos.

ds.

(Signed)

R. M. Black

M. D.

June 9, 1914 (Address) Belvidere Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted;

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bethel Cemetery Md

June 11, 1914

20 UNDERTAKER

ADDRESS

John C. Lippert

Chesapeake City Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

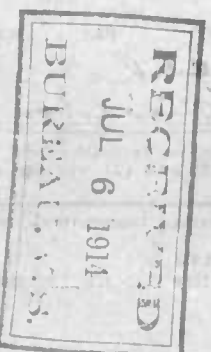
[Approved by U. S. Census and American Public Health Association.]

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*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County *Cecil*Village or City *North East* (No. ....)

St. .... Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. *94*

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *I know Name (Dead Born) Fully*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

*June 30, 1914*  
(Month) (Day) (Year)

7 AGE

If LESS than  
1 day, .... hrs.  
OR .... min. ?

yrs. .... mos. .... ds.

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)9 BIRTHPLACE  
(State or country)*North East*10 NAME OF  
FATHER*Winfield Gully*11 BIRTHPLACE  
OF FATHER  
(State or country)*Cecil county*12 MAIDEN NAME  
OF MOTHER*Bertha Pryor*13 BIRTHPLACE  
OF MOTHER  
(State or country)*Cecil county*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Winfield Gully*

(Address)

*North East Md*

15

Filed

*June 30, 1914 Isaac Biddle*  
*Lucie*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*June 30, 1914*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

, 191, to , 191,

that I last saw h alive on , 191,

and that death occurred on the date stated above, at, m,

The CAUSE OF DEATH\* was as follows:

*Still Born*

(Duration) yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) yrs. .... mos. .... ds.

(Signed)

*A. A. Campbell*, M. D.  
*June 30, 1914* (Address) *North East*\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDEN-  
TAL, SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death yrs. .... mos. .... ds. In the State yrs. .... mos. .... ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Warts church Elk Neck*  
*July 1 1914*  
20 UNDERTAKER  
*W. H. Pierson*  
ADDRESS  
*North East Md*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

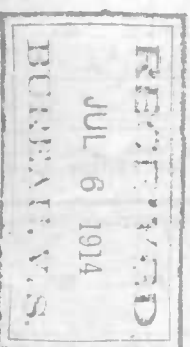
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not formally employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or incurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the heading of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 5750

County BecilVillage or City Rowlandsville (No. \_\_\_\_\_)Registration Dist. No. 96

St.; \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John S. Gillespie

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widower  
(Write the word)

6 DATE OF BIRTH Aug 5, 1938  
(Month) (Day) (Year)

7 AGE 75 yrs. 10 mos. 20 ds. If LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Iron Worker  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Becil Co. Md

10 NAME OF FATHER Robert Gillespie

11 BIRTHPLACE OF FATHER (State or country) Becil Co. Md

12 MAIDEN NAME OF MOTHER don't know

13 BIRTHPLACE OF MOTHER (State or country) don't know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Dora R. Kersery  
(Address) 600 E. 8th St. - Wilmington Del.

15 Filed June 28, 1914 St. C. Keenan  
Cor. Del. Md. REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 22, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1914, to June 24, 1914,

that I last saw him alive on June 24, 1914,

and that death occurred on the date stated above, at 99 m.

The CAUSE OF DEATH\* was as follows:

Left Lobar pneumonia with  
inspiring heart failure and  
collapse (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory (Secondary)

(Signed) W. G. Pack (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
June 28, 1914 (Address) Fort Defiance, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

North Nottingham Presbyterian Church June 28, 1914

20 UNDERTAKER ADDRESS

Slater B. Lark Colona Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

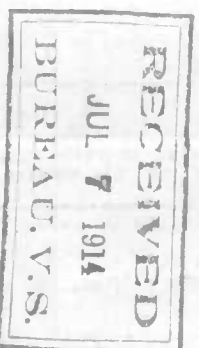
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis" etc. State cause for which surgical operation was undertaken. For violent deaths state means or injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County CecilVillage or City Near Woodlawn (No. 31)Registration Dist. No. 96

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Jane A Jackson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

## 6 DATE OF BIRTH

Feb. 15, 1865  
(Month) (Day) (Year)

## 7 AGE

49 yrs. 4 mos. 17 ds. If LESS than 1 day, hrs. OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

## 9 BIRTHPLACE (State or country)

Cecil Co Ind

## PARENTS

## 10 NAME OF FATHER

Geo W Simmers

## 11 BIRTHPLACE OF FATHER (State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Mary Boyd

## 13 BIRTHPLACE OF MOTHER (State or country)

Unknown

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Jackson

(Address)

Port Deposit Ind

## 15

Filed

June 30, 1914

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

June 27, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from February 14, 1914, to June 27, 1914,

that I last saw her alive on June 26, 1914

and that death occurred on the date stated above, at 7 P. m.

The CAUSE OF DEATH\* was as follows:

Tubercular Enteritis  
Tubercular Peritonitis

(Duration) yrs. 8 mos. ds.Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

G. B. Benson, M. D.  
June 28, 1914 (Address) Port Deposit Ind

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Friends Cemetery June 30, 1914  
Near West Nottingham

## 20 UNDERTAKER

## ADDRESS

W. C. Jackson Blythedale

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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RECEIVED

JUL 7 1914

BUREAU, V. S.

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1 PLACE OF DEATH

5752

County

*Cecil*

Village or City

*New Mannick*

(No. ....)

St. ....

Ward) .....

Registration Dist. No. ....

STATE OF MARYLAND  
CERTIFICATE OF DEATH

96

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

*Annie Eliza Jenkins*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*Black*

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

*married*

6 DATE OF BIRTH

*Oct 25, 1858*  
(Month) (Day) (Year)

7 AGE

*55 yrs. 7 mos. 14 ds.*If LESS than  
1 day, .... hrs.  
OR .... min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

*Home wife*

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

*Delaware*

PARENTS

10 NAME OF FATHER

*Samuel Wilmer*

11 BIRTHPLACE OF FATHER

(State or country)

*Maryland?*

12 MAIDEN NAME OF MOTHER

*Martha Gibson*

13 BIRTHPLACE OF MOTHER

(State or country)

*Don't know. Del.?*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Ruby Jenkins*

(Address)

*Middletown - Del. (R.D.)*

15

Filed

*6/9*

1914

*J. H. Black*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*June 8, 1914*  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

*July 4, 1914, to June 8, 1914,*that I last saw him alive on *June 7<sup>th</sup>, 1914*and that death occurred on the date stated above, at *12:15 P.m.*

The CAUSE OF DEATH\* was as follows:

*Chronic Interstitial Nephritis*(Duration) *1* yrs. *+* mos. ds.Contributory  
Secondary*Cardiac Dilatation*(Duration) *6* yrs. *6* mos. ds.

(Signed)

*Dorsey C. Lewis*

, M. D.

*6/8, 1914 (Address) Middletown - Del.*

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs. .... mos. .... ds.

In the

State

yrs. .... mos. .... ds.

Where was disease contracted,  
It not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Middletown Del.**June 10, 1914*

20 UNDERTAKER

ADDRESS

*Andrew J. Green**Middletown*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

2222

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RECEIVED

JUL 6 1914

BUREAU, V. S.

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1 PLACE OF DEATH County <u>Cecil</u>		5753	STATE OF MARYLAND CERTIFICATE OF DEATH		90
Village or City <u>Near Harwick</u> (No. _____)		St.; _____ Ward		Registration Dist. No. _____	
2 FULL NAME <u>Margaret Jones</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)			
6 DATE OF BIRTH <u>Unknown</u> , 18 <u>63</u> (Month) (Day) (Year)					
7 AGE <u>51</u> yrs. <u>unknown</u> mos. <u>unknown</u> ds.		If LESS than 1 day, _____ hrs. OR _____ min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS	10 NAME OF FATHER <u>Philip Brown</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>				
	12 MAIDEN NAME OF MOTHER <u>Lizzy Kennard</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wm. H. Jones</u> (Address) <u>Harwick</u>					
15 Filed <u>June 11, 1914</u> <u>J. H. Black</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>6</u> / <u>10</u> , 191 <u>4</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____ alive on _____, 191____, and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:					
<u>Paralysis of Heart</u> (Duration) _____ yrs. _____ mos. _____ ds.					
Contributory <u>Bright's Disease</u> (Duration) _____ yrs. _____ mos. _____ ds.					
(Signed) <u>Wm. P. Dean</u> Doctor <u>Wm. P. Dean</u> <u>June 10</u> , 191 <u>4</u> (Address) <u>Edmon</u> <u>Wm. P. Dean</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Assessors M D</u>				DATE OF BURIAL <u>June 13</u> , 191 <u>4</u>	
20 UNDERTAKER <u>Andrew J. Green</u>				ADDRESS <u>Middle town</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

Del



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

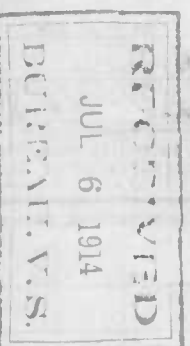
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Wholesale*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestive," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County

Cecil

5754

71

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

Village or City

Liberty Grove

(No. ....)

St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

May Cordelia Jones

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

7

## 4 COLOR OR RACE

B

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED  
(Write the word)

Single

## 6 DATE OF BIRTH

June 14, 1913

(Month)

(Day)

(Year)

## 7 AGE

1

yrs.

mos.

ds.

It LESS than  
1 day, .... hrs.  
OR .... min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9 BIRTHPLACE  
(State or country)

Md.

## PARENTS

## 10 NAME OF FATHER

Lawrence J. Jones

11 BIRTHPLACE OF FATHER  
(State or country)

Md.

## 12 MAIDEN NAME OF MOTHER

Charlotte Jones

13 BIRTHPLACE OF MOTHER  
(State or country)

Md.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Maymen Jones

(Address)

Liberty Grove, Md.

## 15

Filed June 16, 1914

H. C. Lawrence

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

June 14, 1914

(Month)

(Day)

(Year)

## 17

I HEREBY CERTIFY, That I attended deceased from

June 14, 1914, to June 14, 1914,

that I last saw him alive on June 14, 1914,

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH\* was as follows:

Infantile Convulsions  
 I do not know cause of  
 Convulsions (Duration) .... yrs. .... mos. .... ds.

Contributory  
(Secondary)

died in continued convulsions  
 (Duration) .... yrs. .... mos. .... ds.

(Signed)

W. G. East

M.D.

June 14, 1914 (Address) Liberty Grove, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted,  
 If not at place of death?

Former or  
 usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Mt Zion Cemetery

June 16th, 1914

## 20 UNDERTAKER

## ADDRESS

State B. East

Colon Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

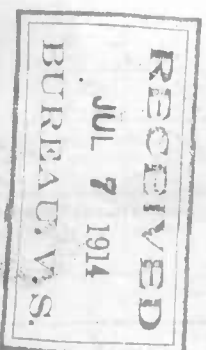
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 5755

County Cecil

Village or City Elk Neck (No. 120) St; Ward

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No. 94

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME George Miller Matthews

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widower  
(Write the word)

6 DATE OF BIRTH Dec. 2, 1843  
(Month) (Day) (Year)

7 AGE 70 yrs. 6 mos. 9 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Pullman Conductor  
(b) General nature of industry, business, or establishment in which employed (or employer) "

9 BIRTHPLACE (State or country) Belvidere N. J.

10 NAME OF FATHER John Matthews

11 BIRTHPLACE OF FATHER (State or country) Bucks Co. Pa

12 MAIDEN NAME OF MOTHER Liza Weller

13 BIRTHPLACE OF MOTHER (State or country) Belvidere N. J.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) St. A. White  
(Address) North East md

15 June 13, 1914 Legislative  
Filed REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 11<sup>th</sup>, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from January 1913 to June 11, 1914, that last saw him alive on June 10<sup>th</sup>, 1914

and that death occurred on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH\* was as follows:

Cardio-Vascular Renal Disease

(Duration) yrs. mos. ds.

Contributory (Secondary) Anemia

(Duration) yrs. mos. ds.

(Signed) W. C. Carver, M. D.  
June 13, 1914 (Address) North East md

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL London Park DATE OF BURIAL June 15, 1914

20 UNDERTAKER A. M. Pearson ADDRESS North East md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

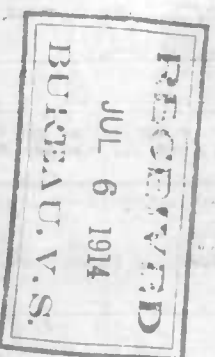
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*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin: "Oncocancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestial," "Scuffle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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<sup>1</sup> PLACE OF DEATH 5756  
County Cecil

Village or City Elkton (No. \_\_\_\_\_, \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

<sup>2</sup> FULL NAME Ricketts Nelson

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

<sup>3</sup> SEX Male <sup>4</sup> COLOR OR RACE White <sup>5</sup> SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

<sup>6</sup> DATE OF BIRTH July 31, 1870  
(Month) (Day) (Year)

<sup>7</sup> AGE 43 yrs 10 mos 24 ds. It LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

<sup>8</sup> OCCUPATION  
(a) Trade, profession, or particular kind of work Clerk  
(b) General nature of industry, business, or establishment in which employed (or employer) Fire Ins. office

<sup>9</sup> BIRTHPLACE (State or country) Maryland

<sup>10</sup> NAME OF FATHER W. R. Nelson

<sup>11</sup> BIRTHPLACE OF FATHER (State or country) Pa

<sup>12</sup> MAIDEN NAME OF MOTHER Mary Jones

<sup>13</sup> BIRTHPLACE OF MOTHER (State or country) Ind

<sup>14</sup> THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John D. Tucker

(Address) Elkton Ind

<sup>15</sup> June 27, 1914 J. Frank Frayer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

<sup>16</sup> DATE OF DEATH June 24, 1914  
(Month) (Day) (Year)

<sup>17</sup> I HEREBY CERTIFY, That I attended deceased from November 1912 to June 24, 1914.

that I last saw him alive on June 24, 1914

and that death occurred on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH\* was as follows:

Primary lateral sclerosis of spinal cord

(Duration) 3 yrs 5 mos ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs \_\_\_\_\_ mos \_\_\_\_\_ ds.

(Signed) W. A. Morrison, M. D.  
June 26, 1914 (Address) Elkton, Ind

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

<sup>18</sup> LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

<sup>19</sup> PLACE OF BURIAL OR REMOVAL Elkton Ind DATE OF BURIAL June 27, 1914

<sup>20</sup> UNDERTAKER Wissinger & Piffle ADDRESS Elkton

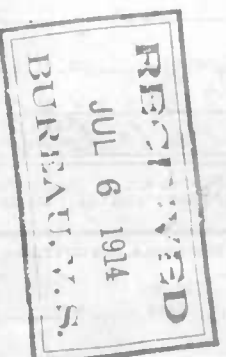
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1 PLACE OF DEATH <i>Cecil</i>		5757		19		STATE OF MARYLAND CERTIFICATE OF DEATH	
County		Village or City <i>Near Port-Deposit</i>		St. Ward		Registration Dist. No. <i>96</i>	
2 FULL NAME <i>Mary Catherine Fouben Schupbach</i>		[If death occurred in a hospital or institution, give Us NAME instead of street and number.]					
PERSONAL AND STATISTICAL PARTICULARS							
3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>Married</i>					
6 DATE OF BIRTH <i>May 31</i>		1852					
7 AGE <i>62</i>		It LESS than 1 day.....hrs. OR.....min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer)		<i>Housewife</i>					
9 BIRTHPLACE (State or country)		<i>Howard Co.</i>					
PARENTS	10 NAME OF FATHER	<i>William Fouben</i>					
	11 BIRTHPLACE OF FATHER (State or country)	<i>Ireland</i>					
	12 MAIDEN NAME OF MOTHER	<i>Unknown</i>					
	13 BIRTHPLACE OF MOTHER (State or country)	<i>Unknown</i>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE							
(Informant)		<i>Ferdinand Schupbach</i>					
(Address)		<i>Port-Deposit</i>					
15		Filed <i>June 22</i> , 1914 <i>J. R. Garrison</i>					
16		REGISTRAR <i>Port-Deposit Md</i>					
MEDICAL CERTIFICATE OF DEATH							
16 DATE OF DEATH		<i>June 20</i> , 1914					
17		I HEREBY CERTIFY, That I attended deceased from <i>June 20</i> , 1914, to <i>June 20</i> , 1914, that I last saw him alive on <i>June 20</i> , 1914, and that death occurred on the date stated above, <i>June 20</i> , 1914, at <i>11 A.M.</i>					
The CAUSE OF DEATH* was as follows: <i>Chronic Endocarditis</i> <i>Acute Degeneration of Heart</i> (Duration) yrs. (Sudden)							
Contributory Secondary (Duration) yrs. mos. ds.							
(Signed) <i>Wm. P. Dean</i> Coroner, <i>June 20</i> , 1914 (Address) <i>Elkton Md</i>							
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.							
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)							
At place of death		yrs. mos. ds.		In the State		yrs. mos. ds.	
Where was disease contracted, If not at place of death?							
Former or usual residence							
19 PLACE OF BURIAL OR REMOVAL				DATE OF BURIAL			
<i>St Marks Cemetery</i>				<i>June 22</i> , 1914			
20 UNDERTAKER				ADDRESS			
<i>W C Jackson</i>				<i>Blytheville</i>			
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.							

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JUL 7 1914

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

5758

County

Cecil

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

96

Village or City

Rowlandville

(No.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

M. Mary Springer

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

6 DATE OF BIRTH

Unknown

(Month)

(Day)

1 (Year)

7 AGE

About 80 years.

yrs.

mos.

ds.

If LESS than  
1 day.....hrs.  
OR.....min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Chester County, Pa.

## PARENTS

10 NAME OF FATHER

Benjamin Springer

11 BIRTHPLACE OF FATHER

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

"

13 BIRTHPLACE OF MOTHER

(State or country)

"

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. T. Creswell

(Address)

Crownings, Md.

15

Filed

June 12, 1914

R. B. Gannon

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June

10

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

June 1, 1913, to

June 10, 1914

that I last saw her alive on

June 9, 1914

and that death occurred on the date stated above, at 5:45 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic nephritis

(Duration)

Uncertain

yrs.

mos.

ds.

Contributory  
(Secondary)

Same as above

(Duration)

yrs.

mos.

ds.

(Signed)

Geo. W. Gillespie

M. D.

June 11, 1914

(Address)

Rowlandville, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Newington Newington County

June 13, 1914

20 UNDERTAKER

ADDRESS

Slater B. Smith

Colma Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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COPIED

JUL 7 1914

BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH **5759**  
 County Pratt  
 Village or City Town Point (No. \_\_\_\_\_, St.; Ward \_\_\_\_\_)  
 2 FULL NAME Stella Borne Whitelock  
 Registration Dist. No. 91

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, ~~MARRIED,~~ ~~WIDOWED,~~ ~~SEPARATED,~~ ~~DIVORCED~~ (Write the word)

6 DATE OF BIRTH Stella Borne, 1 (Month) (Day) (Year)  
 7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work \_\_\_\_\_  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Town Point Md

PARENTS

10 NAME OF FATHER Chas. Whitelock  
 11 BIRTHPLACE OF FATHER (State or country) Maryland  
 12 MAIDEN NAME OF MOTHER Pauline Munford  
 13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 Informant Chas. Whitelock  
 (Address) Town Point

15 Filed 6/21, 1914 W. Lawdell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Stella Borne, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1914, to June 21, 1914, that I last saw her alive June 21, 1914, and that death occurred on the date stated above, at 10 a m.  
 The CAUSE OF DEATH\* was as follows:  
Stella Borne  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (Secondary) \_\_\_\_\_  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) T. Jackson Conner, M. D.  
June 21, 1914 (Address) Chesapeake City Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
 At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Where was disease contracted, If not at place of death? \_\_\_\_\_  
 Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Pratt County, on Farm DATE OF BURIAL June 21, 1914  
 20 UNDERTAKER Buried by Chas. Whitelock ADDRESS Town Pt

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia"; unqualified, is indefinite); *Tuberculosis of lung*, *meninges*, *peritonaeum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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5760

## 1 PLACE OF DEATH

County

Cecil

Village or City

Near Earleville

(No.)

29

St.; Ward)

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Elsie Wilson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

## 6 DATE OF BIRTH

*12 16 1900*  
(Month) (Day) (Year)

## 7 AGE

*13 yrs 5 mos 24 ds.* OR LESS than 1 day, hrs. min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

*At School*

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE (State or country)

*Cecil Co., Md.*

## PARENTS

## 10 NAME OF FATHER

*Phillip Wilson*

## 11 BIRTHPLACE OF FATHER (State or country)

*Cecil Co., Md.*

## 12 MAIDEN NAME OF MOTHER

*Maggie Brooks*

## 13 BIRTHPLACE OF MOTHER (State or country)

*Cecil Co., Md.*

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Philip Wilson*

(Address)

*Earleville, Md.*

## 15

Filed

*June 13, 1914**J. H. Black*

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

90

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

*6 11 1914*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *May 1st* 1914, to *June 11* 1914

that I last saw her alive on *June 11* 1914

and that death occurred on the date stated above, at *6 P. m.*

The CAUSE OF DEATH\* was as follows:

*Acute Miliary Tuberculosis*(Duration) yrs. *1* mos. *11* ds.Contributory  
Secondary(Duration) yrs. *1* mos. *11* ds.

(Signed)

*J. M. Black*, M. D.

*June 13, 1914* (Address) *Cecil Co., Md.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Ballantrach Cemetery* *6/14* 1914

## 20 UNDERTAKER

## ADDRESS

*John F. Caffery* *Cecil Co., Md.*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of.....; (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic watery heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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